prescribed for every refractory moderate to severe patient with IBD treated at the centre between January 2014 and November 2017. For each patient dispensed treatments, switches and reason for switches were analysed.

Results Eight-hundred and fourteen patients with IBD treated with biologics were included: Adalimumab (42.7%), Infliximab (27.4% originator; 14.4% biosimilar), Golimumab (6.8%) and Vedolizumab (8.7%). Five per cent of overall in-treatment patients changed treatment. Switch rates were: 8.5% from Infliximab originator to Vedolizumab, 3.6% from Golimumab to Adalimumab, 1.8% from Golimumab to Infliximab biosimilar, 12.8% from Infliximab biosimilar to Vedolizumab, 2.8% from Vedolizumab to Infliximab biosimilar, 4.5% from Infliximab originator to Infliximab biosimilar and 1.7% from Infliximab biosimilar to originator. Reasons for switching were inefficacy (61%) or treatment cost reduction (39%).

Conclusion Analysis showed a high variability in biological therapy prescription trends at the centre, which could be related to patients' characteristics. Even in the absence of clear comparison data between different treatments, clinical choices included all biological treatments approved in Italy, which were almost always effective and were associated with a low overall switch rate.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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11SG-034 A CRITICAL LOOK AT ERRONEOUS INCENTIVES AND LACKING LEGAL FRAMEWORK AS DRIVERS OF MEDICINES SHORTAGES AND OBJECTORS TO PROBLEM-SOLVING APPROACHES

^{1,2}H Jenzer*, ¹L Sadeghi, ³P Maag, ¹F Scheidegger-Balmer, ¹K Uhlmann, ¹G Schumacher, ³S Groesser. ¹Bern University of Applied Sciences BFH, Health, Bern, Switzerland; ²University Hospital of Psychiatry PUK ZH, Hospital Pharmacy, Zürich, Switzerland; ³Bern University of Applied Sciences BFH, School of Engineering and Information Technology- Industrial Engineering and Management Science, Biel – Bienne, Switzerland

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Background Medicines shortages deteriorate. No prompt solution is foreseen. Interest vary between stakeholder values and patient outcomes. More analyses will not contribute substantially to relief. Distinct contributions to the solution of problems are urgently needed.

Purpose This work aims to report on the causes and solutions of medicines' shortages.

Material and methods Twenty-three lead stakeholders were interviewed. Erroneous incentives and/or system shortcomings and potential to improve shortages prevalence were evaluated. Applied methodologies comprise qualitative research, system dynamics-aided simulation and best hospital pharmacy practices.

Results One-hundred and thirteen relevant causes of medicines' shortages and 126 approaches to improvement were issued in mind-maps.

Governments' actions are limited to epidemiology and responsibility for public health. The State monopoly serves to fix reference pricing. However, free trade is not touched while macro-economy runs satisfyingly. Commodity exchange of starting materials might be a break-out option. Dogmata such as Public Health as cost booster need revision. In fact, added values arising from healed patients being reintegrated into work processes should be validated.

Manufacturers do not opt for business without free trade and guidance-independent decision making. Unmet gain perspective and break-even induce deregistration for economic reasons. Upcoming personalised medicine requests precision medicine, whereas large-scale production is transferred to low-income countries, although quality, reliability and capacity are undoubtedly inferior. The construction of new production plants have to anticipate two upcoming decades. Precious APIs and products could be sustained by transfer to intermediate scale manufacturers.

(Pre-) wholesalers carry burdens of capital bound for stock-keeping. Replenishing is not compensated. GPS-aided medicines spotting from source to consumer might help to over-view and warrant steady flow.

In the past, hospital pharmacy manufacturing has been reduced for economic reasons. Vulnerabilities in the supply chain and of patient outcome were not considered. The revised truly inspiring Swiss Act on Medicinal Products requests more independence and ability of hospital pharmacies to produce formula hospitalis and magistralis.

Conclusion Some stakeholders still have the best (i.e. unrestricted gains) and the worst alternatives (i.e. loss of reputation, unmet break-even points, new legislation with shifting tasks and responsibilities to the State) to voluntarily negotiated agreements. Therefore, negotiations led by a referee board and a true private/public partnership might markedly improve the availability of medicines.

REFERENCES AND/OR ACKNOWLEDGEMENTS

SNSF/BFH/COST.

No conflict of interest.

11SG-035 URETERAL MAGNETIC CATHETER: AN EASY AND ECONOMICAL WAY TO REMOVE THE DEVICE

A Jouvance-Le Bail*, A Lemée, CP Mortier, M Girard de Courtilles, F Lesourd, L Gueneret. CHU Pontchaillou, Pharmacy, Rennes, France

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Background During the urology device tender, a new ureteral catheter (UC) was proposed: the UROTECH's MAGNETIC BLACK-STAR kit, which is three times more expensive than the traditional UC (non-magnetic rigid polyurethane double loop UC). Its bladder side magnet allows its removal thanks to a magnetic recovery device. As this new technique is faster and requires no endoscope or re-sterilisable equipment, the additional cost of purchase would be offset during the withdrawal, and the discomfort would be reduced for the patient, according to the manufacturer.

Purpose We wanted to estimate the overall cost differences for our hospital between the BLACK-STAR UC and a traditional UC, and compare our results with an estimation made by the manufacturer to another hospital.

Material and methods The estimation is based on the time spent by the nurse and surgeon, and the exhaustive listing of the devices used during the removal procedure of the two UC, in men and women. The estimated costs of using re-sterilisable medical devices include depreciation and sterilisation. For the flexible endoscope, this was evaluated in 2015 in our hospital by also integrating the maintenance cost. As the placement technique is identical for both UC, the cost of the equipment used was not evaluated.

Results In men the cost is estimated at €209 for the usual UC removed by flexible cystoscopy versus €124 for the magnetic UC (gain of €85 with the magnetic UC, higher than the €63 announced). In women, the cost is estimated at €84 for the usual UC removed by rigid cystoscopy, versus €124 for the magnetic UC (€40 more expensive with the magnetic UC, contrary to the gain of €32 announced). Since the magnetic UC was placed but not yet removed, this estimation does not include the cost of hospital staff.

Conclusion The economic evaluation conducted in our hospital is largely in favour of the use of the magnetic UC in men. Although this is not the case for women, its referencing to replace the current UC could save more than €12 000 per year in our hospital, based on 2017 consumption. Patient satisfaction also remains to be assessed.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

1ISG-036 THE IMPACT OF HOSPITAL PHARMACY INFRASTRUCTURE AND HUMAN RESOURCES ON MEDICINES OPTIMISATION AND INTEGRATED CARE

¹D Gennimata, ²K Nikou, ³L Kouri*, ¹F Marini, ⁴K Perdikouri. ¹'Korgialenio-Benakio' Red Cross General Hospital, Pharmacy, Athens, Greece; ²General Hospital of Chest Diseases 'Sotiria', Pharmacy, Athens, Greece; ³Paediatric Hospital 'Aglia Kyriakou', Pharmacy, Athens, Greece; ⁴'Spiliopoulou' Hospital, Pharmacy, Athens, Greece

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Background The hospital pharmacy (HP) is frequently among the most multitasking departments of the institution. Although administrative tasks, concerning all steps of the medicines supply chain, tend to be a priority for several hospital managers, the key role of medication review that hospital pharmacists play in medicines optimisation (MO) and integrated care (IC) is often ignored.

Purpose The purpose of the present study is to identify the degree of prioritisation in MO steps, among the participating hospital pharmacies (general, paediatric and terminal care) located in the same healthcare region and to assess the impact of infrastructure and human resources on the overall organisation of tasks assigned to the HP.

Material and methods During the first semester of 2018, pharmacists from the participating hospitals registered MO tasks, IC initiatives and relevant attributes (e.g. range, distribution) in semi-structured diaries, on a weekly basis, including relevant time spent on each commitment. Personnel capacity and appropriateness of infrastructure were also recorded. Data were analysed by Excel and SPSS.

Results Great differences concerning the type of daily tasks in each hospital pharmacy were observed, e.g. in compounding, administrative management, procurement and clinical services. The availability of both pharmacists and supportive personnel in combination with the appropriateness of infrastructure had a major impact on time allocated at every task. Administrative responsibilities and supply chain maintenance were highly prioritised in all cases, whereas a variation concerning the provided clinical services from 20% to 50% as a percentage of the overall hospital pharmacy activities was described. Furthermore, given the need for customised dosage forms in paediatric hospitals, a significant amount of time and human resources was dedicated to compounding.

Conclusion Although all aspects of MO are considered essential in providing IC to patients, due to a lack of human resources rather than lack of infrastructure, hospital pharmacists are obliged to prioritise administrative and supply chain services over their clinical ones. Therefore, pharmaceutical care remains fragmented and a multidisciplinary approach to patient care is difficult to achieve.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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1ISG-037 HEALTH-RELATED QUALITY OF LIFE IN HEPATITIS C PATIENTS WHO ACHIEVE SUSTAINED VIROLOGICAL RESPONSE TO DIRECT-ACTING ANTIVIRALS: A COMPARISON WITH THE GENERAL POPULATION

¹R Juanbeltz, ¹J Castilla, ¹I Martínez-Baz, ²A O'Leary, ³C Burgui, ⁴J Preciado, ⁴L Ulacia, ⁴B Larrayoz*, ⁴M Sarobe, ⁴R San Miguel. ¹Instituto de Salud Pública de Navarra-Idisna-Cibersp, Transmissible Diseases and Vaccination, Pamplona, Spain; ²National Centre for Pharmacoeconomics- St James's Hospital- Royal College of Surgeons in Ireland, School of Pharmacy, Dublin, Ireland; ³Ciber Epidemiología y Salud Pública Cibersp, Department of Hospital Pharmacy, Pamplona, Spain; ⁴Complejo Hospitalario de Navarra, Department of Hospital Pharmacy, Pamplona, Spain

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Background A short-term benefit on health-related quality of life (HRQoL) has been reported in successfully treated chronic hepatitis C patients with direct-acting antivirals. However, no information exists regarding the HRQoL difference compared to the general population after viral clearance.

Purpose To compare HRQoL outcomes between hepatitis C patients who achieve sustained virological response (SVR) and a sample of the general population.

Material and methods Patients were recruited from May 2016 to April 2017. At post12 SVR time-point, a hospital pharmacist assessed HRQoL using the EQ-5D-5L questionnaire in a telephone interview. Results were compared to those of the general population of the same sex and age obtained from the 2011/12 National Health Survey in Spain. Observed/expected (O/E) ratios for health dimensions (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) and differences between O/E in EQ-5D utility and visual analogue scale (VAS) scores were calculated.

Results Two-hundred and six patients with SVR were studied. Mean age was 52 (SD=9.0) years. Sixty-six per cent were male and 32% were HIV co-infected. According to liver fibrosis, 25% were F0-F1, 47% F2-F3 and 28% cirrhotic. After SVR, patients had more limitation than the general population, especially for the usual activities (O/E=3.1), anxiety/depression (O/E=2.8) and EQ-5D utility (-0.086, p<0.001); however, no difference in VAS score was observed (74.8 vs 76.5 respectively, p=0.210). F0-F1 patients with SVR had minor differences with the general population in mobility (O/E=0.6), self-care (O/E=1.0), usual activities (O/E=1.5) and pain/discomfort (O/E=1.3). However, anxiety/depression was nearly three times more frequent compared to the general population (O/E=2.7). Cirrhotic patients still had worse HRQoL after SVR, especially in usual activities (O/E=4.8) and self-care domains (O/E=3.7), EQ-5D utility values (-0.152, p<0.001) and VAS score (-8.5, p=0.005).

Conclusion HRQoL of chronic hepatitis C patients is considerably lower than that of the general population despite SVR.